2010 Military Health System Conference

Enrollment is the Start not the End

Applying the Operational Art to the Military Medical Mission

Sharing Knowledge: Achieving Breakthrough Performance

CAPT Kevin Berry, MC, USN, special studies

27 January 2010

Joint Task Force National Capital Region Medical

Main Points

- Enrollment is about an insurance product. Can it be a commitment to a healing relationship too?
- Primary Care is a military capability, but not the only way to all ends.
- Common Operating Picture – enrollment in the NCR
- Mission challenge – Quadruple Aim, constraints, population of concern, assignment of an integrator
- Leadership opportunities
  - Improving the patient experience
  - Analyze the mission, build the plan, execute it, assess effectiveness.

Enrollment in the MHS

- ‘Enrollment’ is the method insurance entities use to package health insurance products.
- TRICARE Prime is a legally defined insurance product for eligible beneficiaries.

Military Medicine*

Delivering health/medical capabilities to the Joint warfighters and to the men and women, retirees and family members of the Armed Force. Anytime. Anywhere.

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference. A working concept. Not an official mission statement of any part of the DoD or Military Department.)

Joint Military Medical Enterprise*

- End state is an integrated world class military medical capability §
- Our national military medical capability in the National Capital Regionº

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference. A working concept. Not officially defined in an approved Terms of Reference document.)

§ Honorable Gordon England, DTM Establishing Authority for Joint Task Force – National Capital Region/Medical (JTF CapMed) and JTF CapMed Transition Team (Unclassified), (12 September 2007, Deputy Secretary of Defense)

º VADM John Matezcun, Commander JTF CAPMED, verbal guidance to his staff, 22 Jan 2010

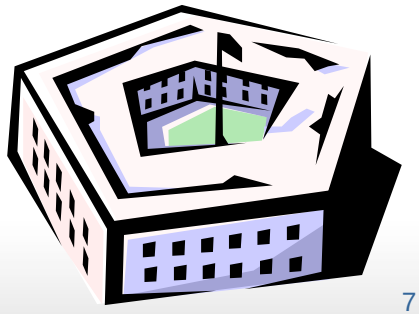
MHS Transformation 2005-2007

- Based on the 2005 Quadrennial Review & Medical Readiness Review the MHS Transformation Final Report stated the traditional notion of a dual mission – operational and peacetime healthcare – was replaced by ...
- "The MHS is first and foremost a Military Health System."*

* RADM John Mateczun, Director, "Military Health System Transformation Implementation Plan: Final Report" (Military Health System Office of Transformation (MHS-OT)) July 2007, p. 1-2.

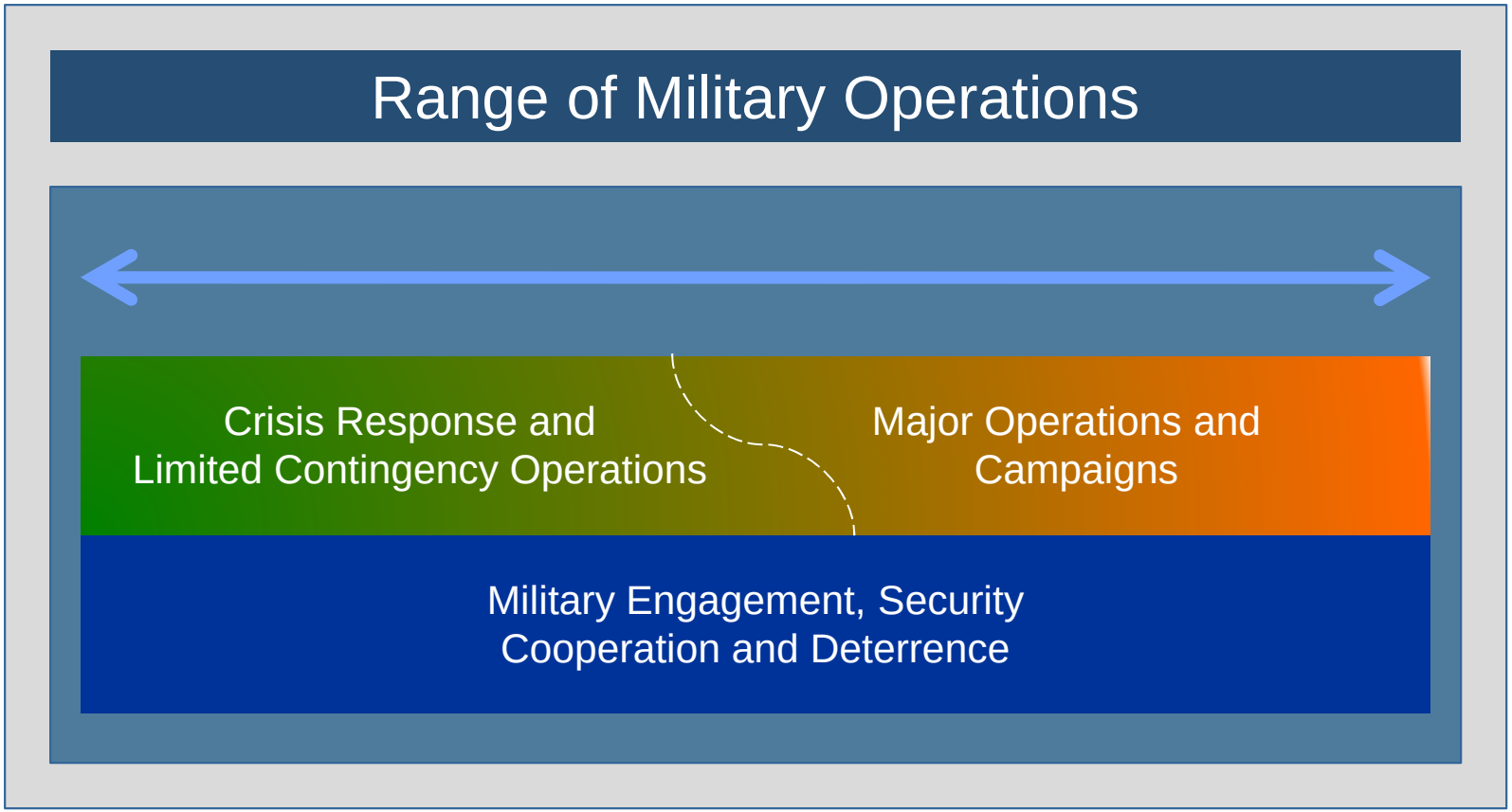
The Origin of the Mandate

- Military power is one of four powers inherent in sovereign nations – Diplomatic, Information, Military, Economic.*
- At the highest level of strategic planning Military Medicine is the instantiation of military capability applied as needed for National Defense, National Security, and National Health.
- Military Medicine is employed anywhere across the range of military activities.



* Director for Operational Plans and Joint Force Development (J-7), "Doctrine for the Armed Forces of the United States, Joint Publication 1 (JP1)", (1 May 2007, Change 1 20 March 2009, Commander, United States Joint Forces Command, Joint Warfighting Center Code JW100, Suffolk, VA, p. I-16.)

Range of Military Operations*



* CJFC, JP1, (2007, chg 1 2009, p. XX)

Military Medical Capabilities

- 'Readiness' is much more than the measurements of 'Individual Medical Readiness' and 'Psychological Health'.
- Military medical readiness meets the capabilities-based planning requirements of Service and Joint warfighters.*
  - Services: Army, Marine Corps, Navy, Air Force
  - Joint functions: air, space, maritime, land
    - Medical is a function in Direct Support of JFHQ/JTF-NCR §

* Director for Operational Plans and Joint Force Development (J-7), "Unified Action Armed Forces, Joint Publication 0-2" (1 July 2001, Commander, United States Joint Forces Command, Joint Warfighting Center Code JW100, Suffolk, VA, p. V-3.)
• § JTF CAPMED Supplemental Plans, 3400, 3600, 3591

Proposed Operating Environment Construct*

Three States of the MHS

- **In garrison** – resourced and managed for reconstitution, readiness, training and innovation activities of assigned forces.
- **Deployable** – capabilities immediately available as assignable forces, for Joint / Service requirements.
- **Mobilized** – readiness capabilities employed.

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

JTF CAPMED*

- First standing JTF with a medical function
- Mission focused
- Effective
- Efficient when and where possible
- Assigned Forces
  - Cohesive
  - Joined through Unity of Purpose

* Adapted from VADM John Mateczun, “About Us” (Sep 2007 http://www.nca-integration.amedd.army.mil/pages/aboutus.asp Retrieved 24 Jan 10).

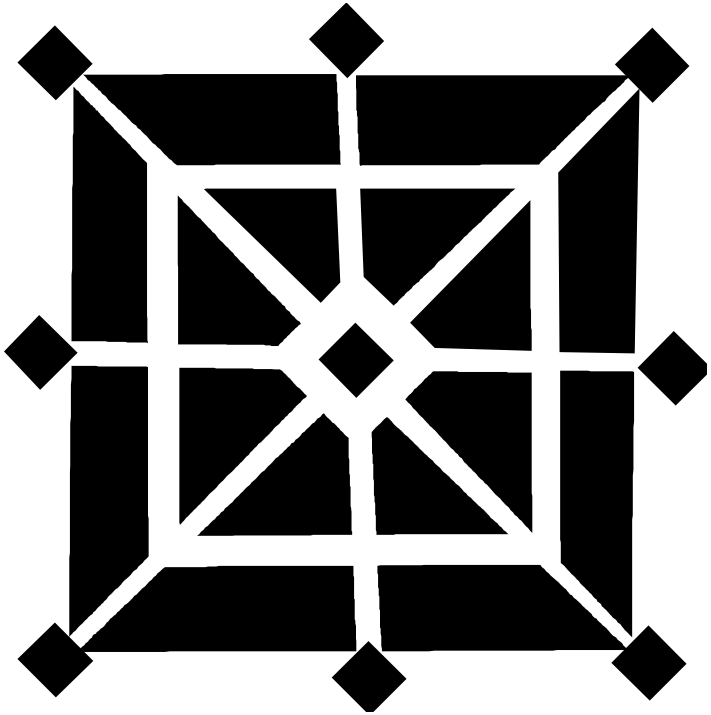
Capabilities-based Planning*

- Applied to the JTF CAPMED Joint Operation Area
- Operates beyond the boundaries of the MTF
- Common Operating Picture
- Cohesive
- Coordinated
- Integrated
- Interoperable

* CJFC, JP1, (2007, chg 1 2009, p. I-11 (CH-1).)

Military Treatment Facilities*

- Comprised of four interlocking indivisible platforms
  - Operational Platform
  - Readiness Platform
  - Training Platform
  - Innovation Platform



* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

Operational Platform*

- MTF has a headquarters Command & Control function over assigned forces
- Central planning
- Decentralized execution
  - Coordinates / integrates the four interlocking platforms in and beyond an MTF
- Manages partnerships and alliances

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

Operational Platform's Mission*

- Health Service Support for local and repatriated Armed Forces, their family members and eligible beneficiaries
- In support of other commands
  - Receive casualties from war
  - Occupational Health
  - And more
- Contingency management
  - Planning and coordinating response

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

Readiness Platform's Mission*

- Individual and subordinate unit readiness.
- Professional currency: In the healthcare arena healthcare professionals & technicians of all types require access to authentic clinical activities in sufficient volume, flow and complexity to remain at the top of their game.

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

Training Platform's Mission*

- Technicians, nurses, administrators, allied health scientists and physicians are in training while in a pre-deployable status.
- Accruing knowledge, skill, judgment, experience sufficient to
  - matriculate, sit for examination, pass competency reviews, achieve certification.

- Sufficient volumes, flows and complexities of clinical activity is a necessary resource.

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

Innovation Platform's Mission*

- Many MTFs operate an innovation platform.
  - In support of Training Platform
  - Service-specific military medical research
  - Congressionally Directed Research
  - Partner with Uniformed Service University of the Health Sciences
  - Partnerships with Universities

  or VHA

* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

Access to Patients

To fulfill our Operational, Readiness, Training and Innovation Platforms requirements we need inputs: money, supplies, facilities, technology, people, leadership, administration.

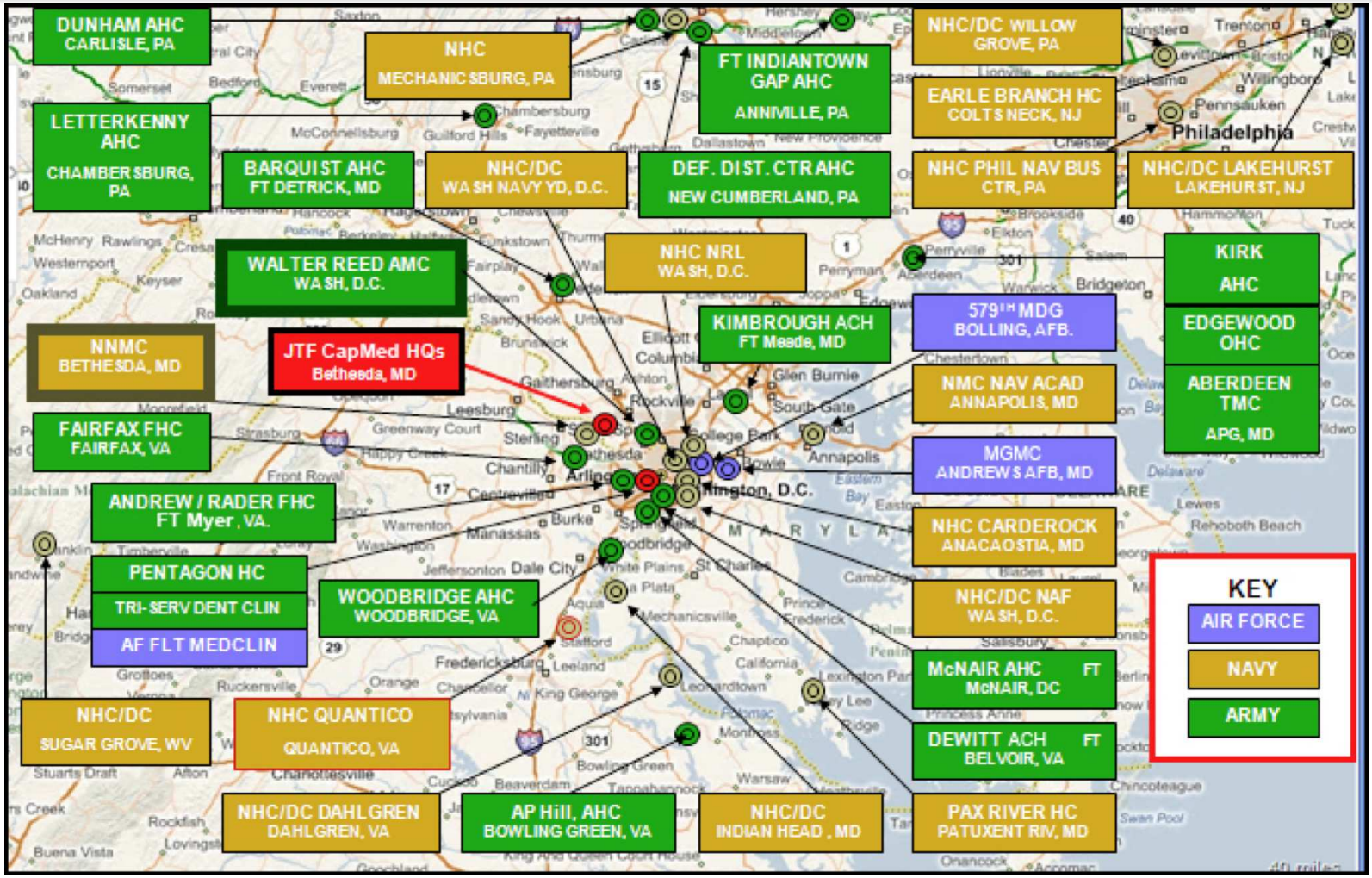
And …we need access to patients.

- How many?
- What kind?
- Only AD and ADFM and only primary care?

The Operational Art

NCR COMMON OPERATING PICTURE

JTF CAPMED JOA – Assigned Forces*



* Deputy Secretary of Defense, DTM Establishing JTF CAPMED, 12 September 2007

The NCR Operating Environment

Future State*

Our two Joint MTFs

- Walter Reed National Military Medical Center
  - Our Military Academic Medical Center &
  - War Casualty Care & Wounded Warrior Village
- Fort Belvoir Community Hospital
  - Our robust community inpatient and ambulatory center
  - War Casualty Care & Warrior Treatment Unit

*Honorable David S. C. Chu, Action Memo, Civilian and Military Personnel Management Structures for the Joint Task Force National Capital Region – Medical (JTF CapMed), (Approved by Honorable Gordon England, Deputy Secretary of Defense, 15 Jan 2009)

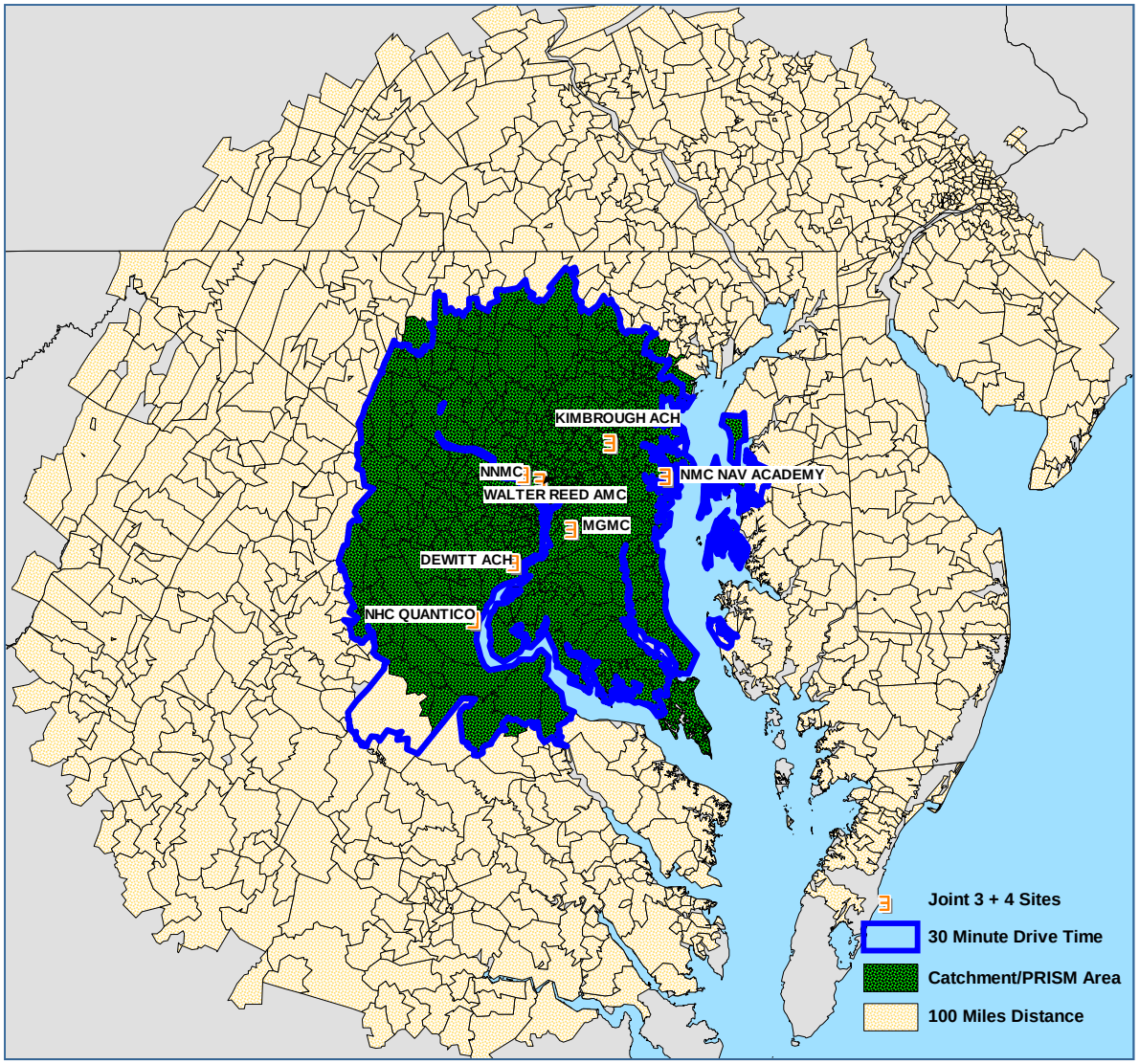
NCR Operating Environment

- USAF Malcolm Grow
  - Located with Aeromedical Support Activity
  - Emergency & Ambulatory Surgery Services
- USA Kimbrough
  - Ambulatory Surgery Services
  - War Casualties Care and Warrior Treatment Unit

NCR Operating Environment

- Large Clinics
  - USN Quantico
  - USN Annapolis
- Special Function Clinics
  - Joint Woodbridge
  - Joint Fairfax
  - Army/Tri-Service Pentagon
- Smaller Clinics
  - 8 Army, Navy and Air Force clinics

NCR MTF Profiles – Noblis Nov 09



DMIS	MTF	Zip
	Inpatient MTFs	
0037	WRAMC	20307
0066	MGMC	20762
0067	NNMC	20889
0123	DeWitt - Belvoir	22060
	Ambulatory MTFs	
0069	Kimbrough	20755
0306	Annapolis	21402
0385	Quantico (inc. 1670 & 1671)	22134

30 Minute Drive Time – Based on JTF supplied drive times for all facilities within 30 miles except for WRAMC and Annapolis (missing data for these zips filled in by Noblis based on zip code to zip code and not exact address to exact address . Yearly comparisons assume zips are consistent through 2004 to 2008 (no changes to boundaries, etc.) 30 minute drive time formula: Less than 31

Catchment/PRISM Area - Based on the Joint 4 + 3 zip codes (40 mile radius for WRAMC, MGMC, NNMC and DeWitt-Belvoir and the 20 mile radius for Kimbrough, Annapolis and Quantico) determined by the MapInfo Zip Point file, MapInfo Zip Boundary file and M2 listed zips for this area. Also taken into consideration are zip codes from the *"Zips Within 100 Miles.xls" file (see source notes on profile sheets).* Catchment/PRISM area formula: Less than 41 or less than 21

100 Miles Distances – Based on JTF supplied distances from the "Zip Within 100 Miles.xls" file. Within 99 miles formula: Less than 100

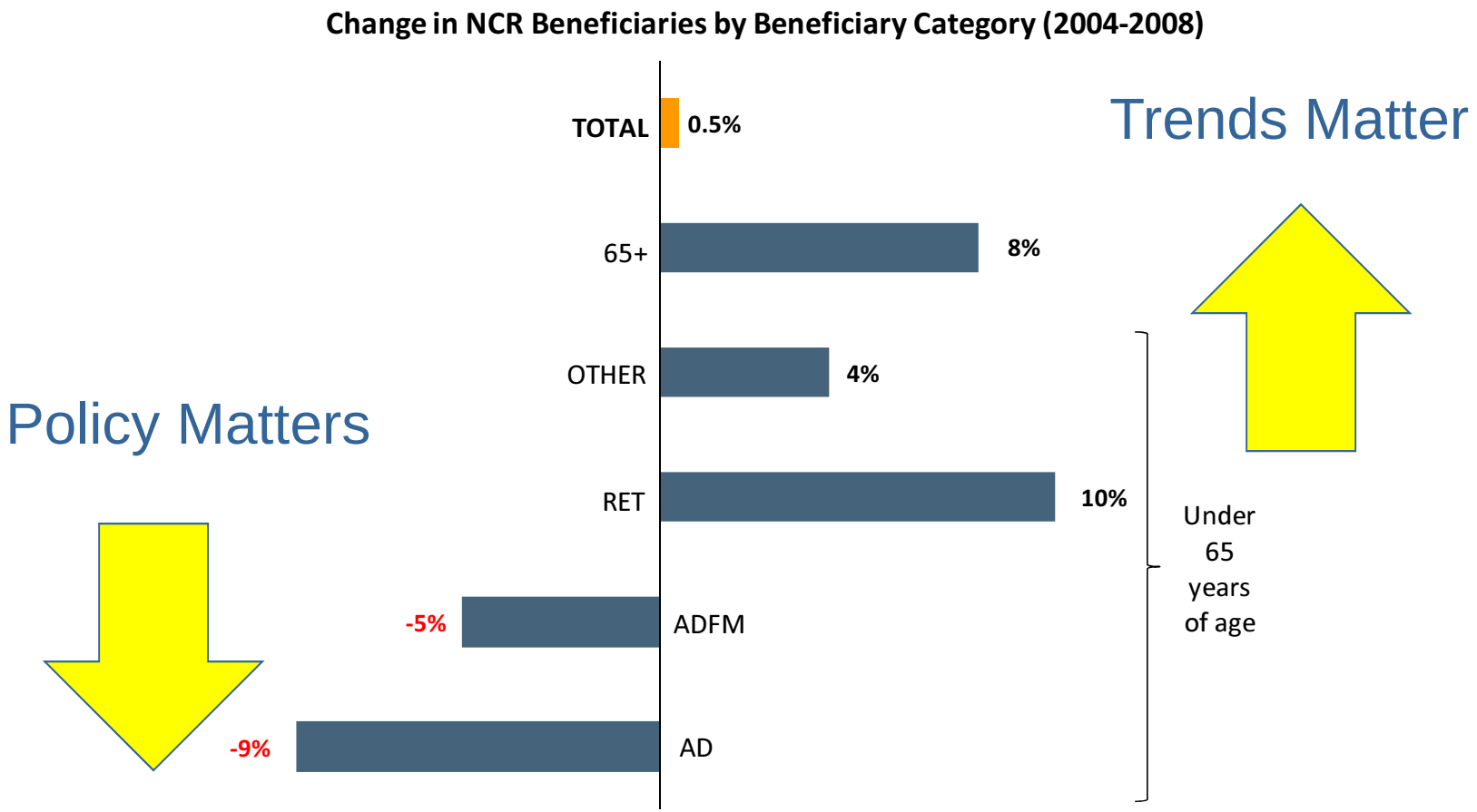
Sources for the following profiles: For Official Use Only: Population (Eligible: DEERS Summary File from M2 pulled on 02OCT09 by Noblis. Enrolled: M2, TRICARE Relationship Summary (DEERS) pulled by Noblis on 02OCT09.) Workload (SIDR pulled on 21SEPT09; SADR on 02OCT09; HCSRI on 21SEPT09; and, HCSR-NI pulled on 22SEPT09 by Noblis.) Drive Time ("Zips Within 100 Miles.xls" forwarded by WRAMC DHPM, 21SEPT09 with supplemental data from MapQuest for WRAMC and Annapolis pulled on 16OCT 09 and 19OCT09.) Map (MapInfo, 19OCT09.)

Eligible Beneficiaries in the NCR*

- **Increased** by 0.5% between 2004 and 2008
  - Under 65 AD **decreased** by 9%
  - ADFM **decreased** 5%
  - 15% of the eligible population is older than 65 years of age
  - 65+age group is growing
    - **Increased** 8% between 2004 and 2008

* Noblis, “National Capital Region (NCR) Market Analysis” (Work product delivered November 2009)

NCR Beneficiaries*



* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

Enrolled Beneficiaries in NCR*

- The overall NCR **enrolled** population **increased** by 3% between 2004 and 2008
- NCR MTF enrollment **declined** by 7%
- In 2008
  - 52% of the NCR beneficiary population was enrolled in a NCR MTF
  - 14% were enrolled in an outside the NCR MTF/Managed Care Contractor
  - 34% were not enrolled

* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

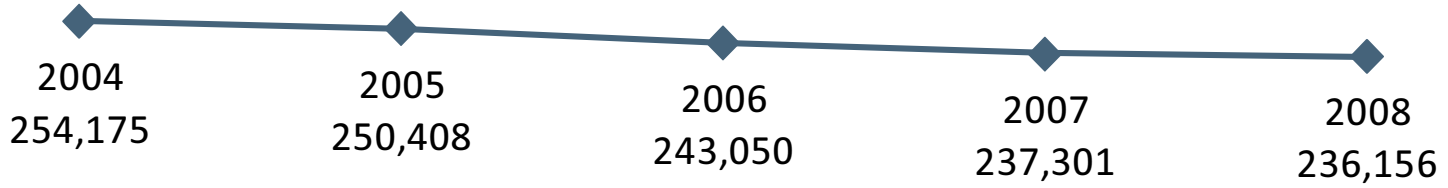
AD ADFM Enrollment in NCR*

- **AD and ADFM** are most likely to be enrolled in a NCR MTF, they comprise more than 50% of the NCR beneficiaries enrolled in a NCR MTF, and have **declined by more than 5%** between 2004 and 2008
- The 65+ population is the least likely to be enrolled, they comprise 8% of the NCR beneficiaries enrolled in a NCR MTF, and their enrollment **declined by 20%** between 2004 and 2008

* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

NCT MTF Enrollment*

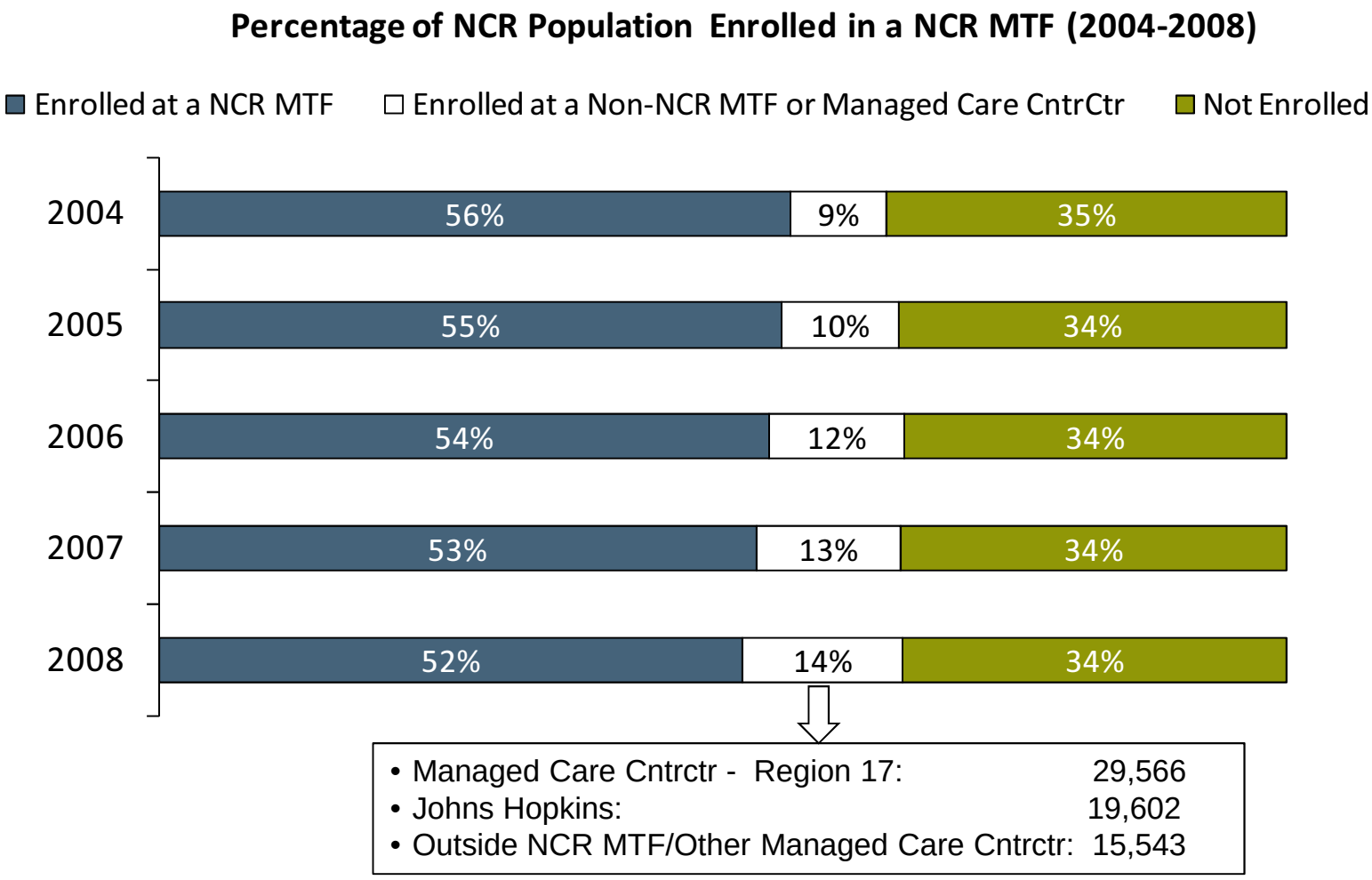
The Number of NCR Benficiaries Enrolled at a NCR MTF (2004 to 2008)



SAME TREND AS IN THE MHS AS A WHOLE

* Noblis, “National Capital Region (NCR) Market Analysis” (Work product delivered November 2009)

NCR Enrolled Population Shifts*



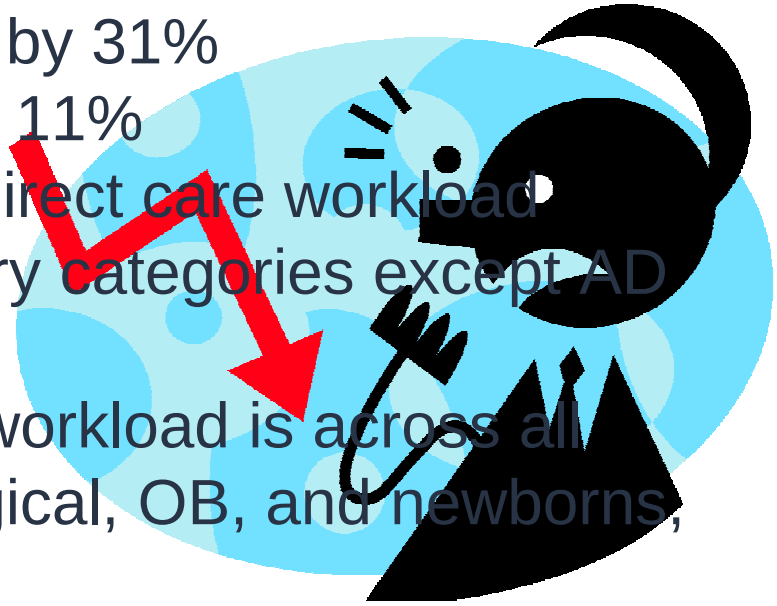
* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

The Operational Art

BEYOND ENROLLMENT

Inpatient Utilization and Market Share in NCR*

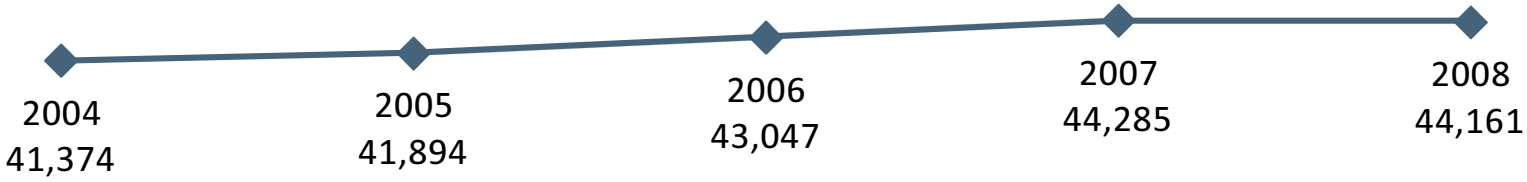
- Inpatient workload of NCR beneficiaries at NCR facilities (direct and purchased care combined) **increased** by 6 percent between 2004 and 2008.
  - Purchased care **increased** by 31%
  - But direct care **declined** by 11%
  - NCR beneficiary inpatient direct care workload **decreased** for all beneficiary categories except AD between 2004 and 2008.
  - The **decrease** in inpatient workload is across all product lines (medical, surgical, OB, and newborns, and psych).



* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

Total NCR Inpatient Care*

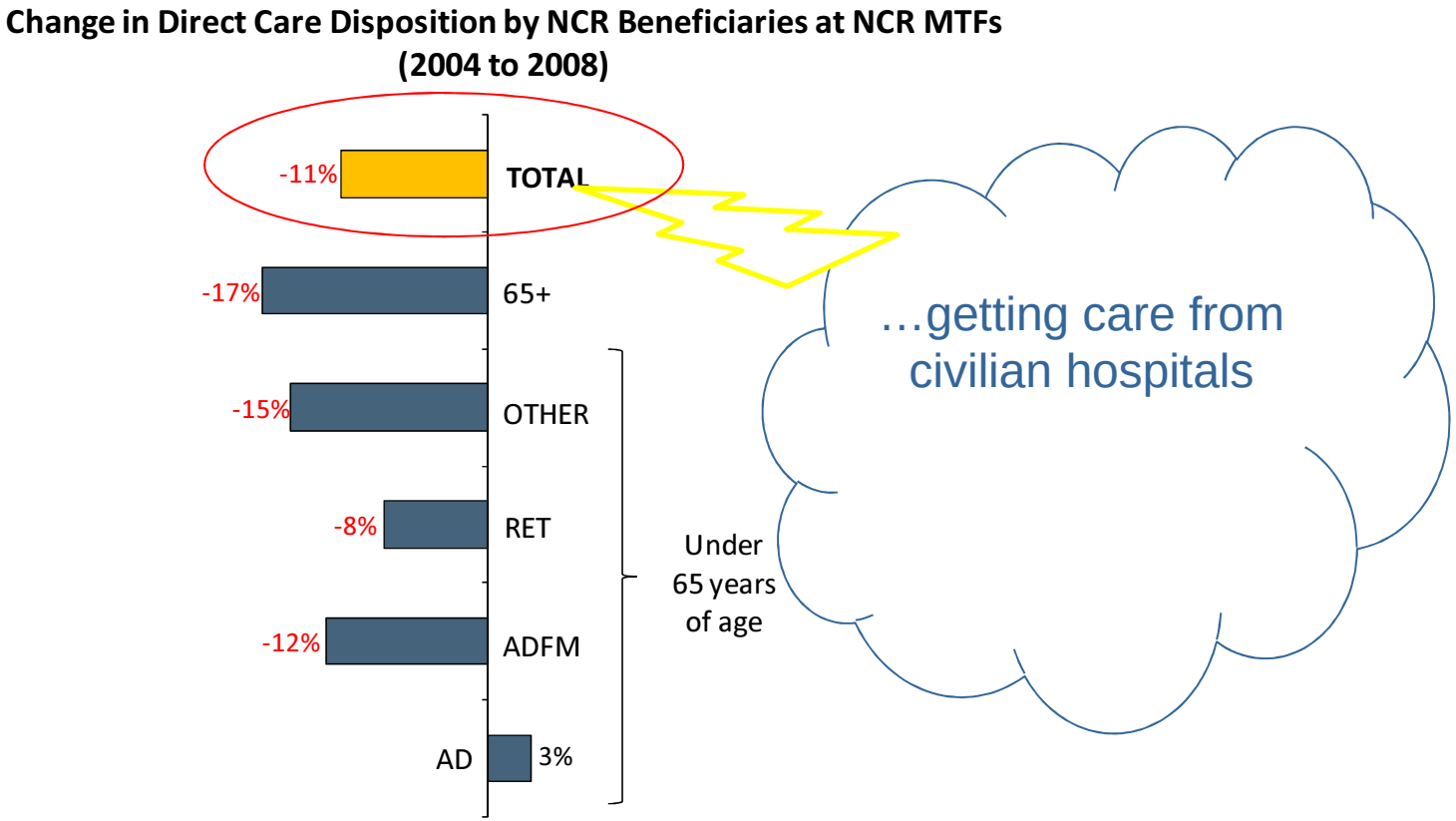
Total Inpatient Disposition by NCR Beneficiaries (Direct and Purchased Care, All NCR and Outlier MTFs and Facilities)



PLENTY OF PATIENTS

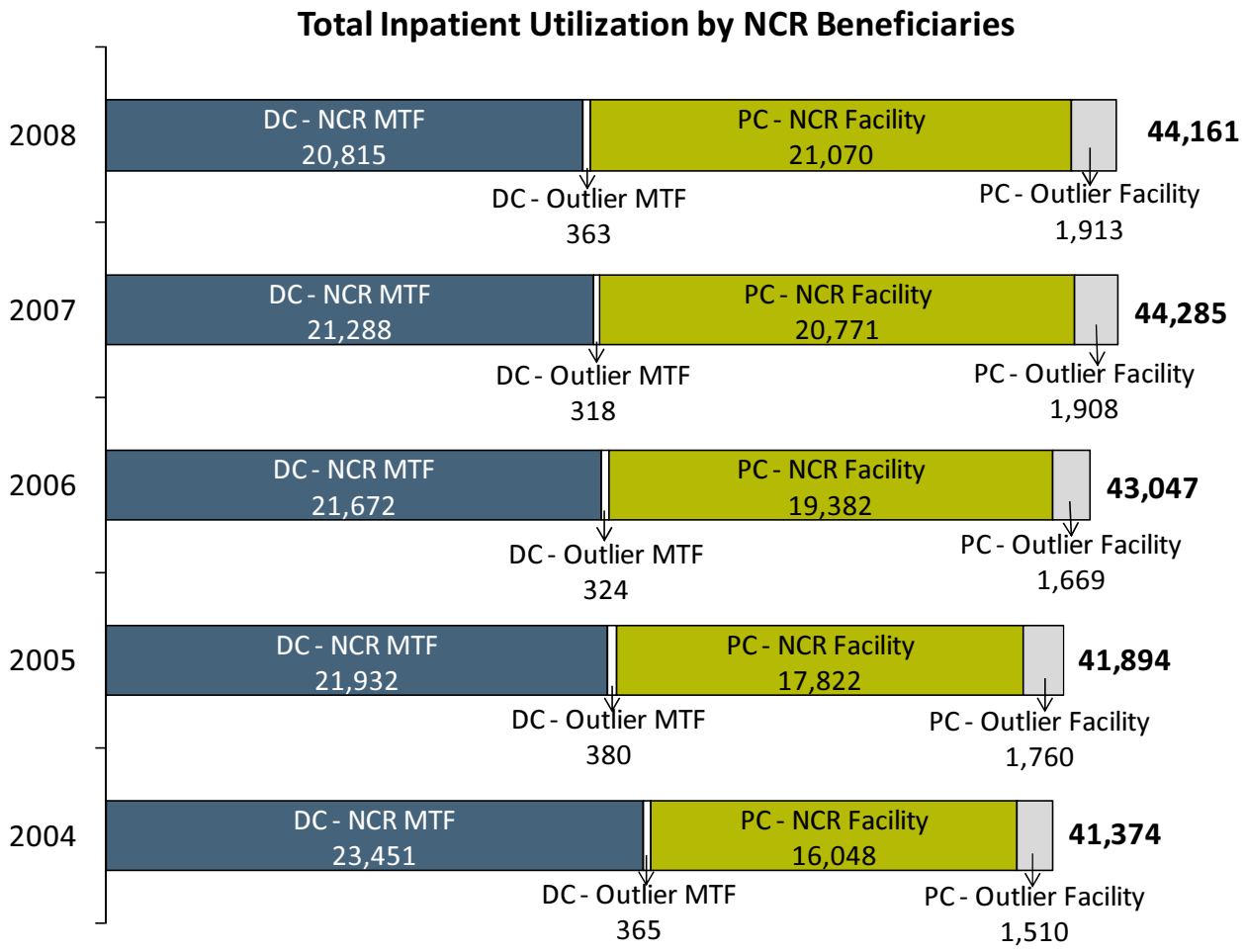
* Noblis, “National Capital Region (NCR) Market Analysis” (Work product delivered November 2009)

NCR Direct Care Inpatient Disposition*



* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

Inpatient Utilization by NCR Beneficiaries*

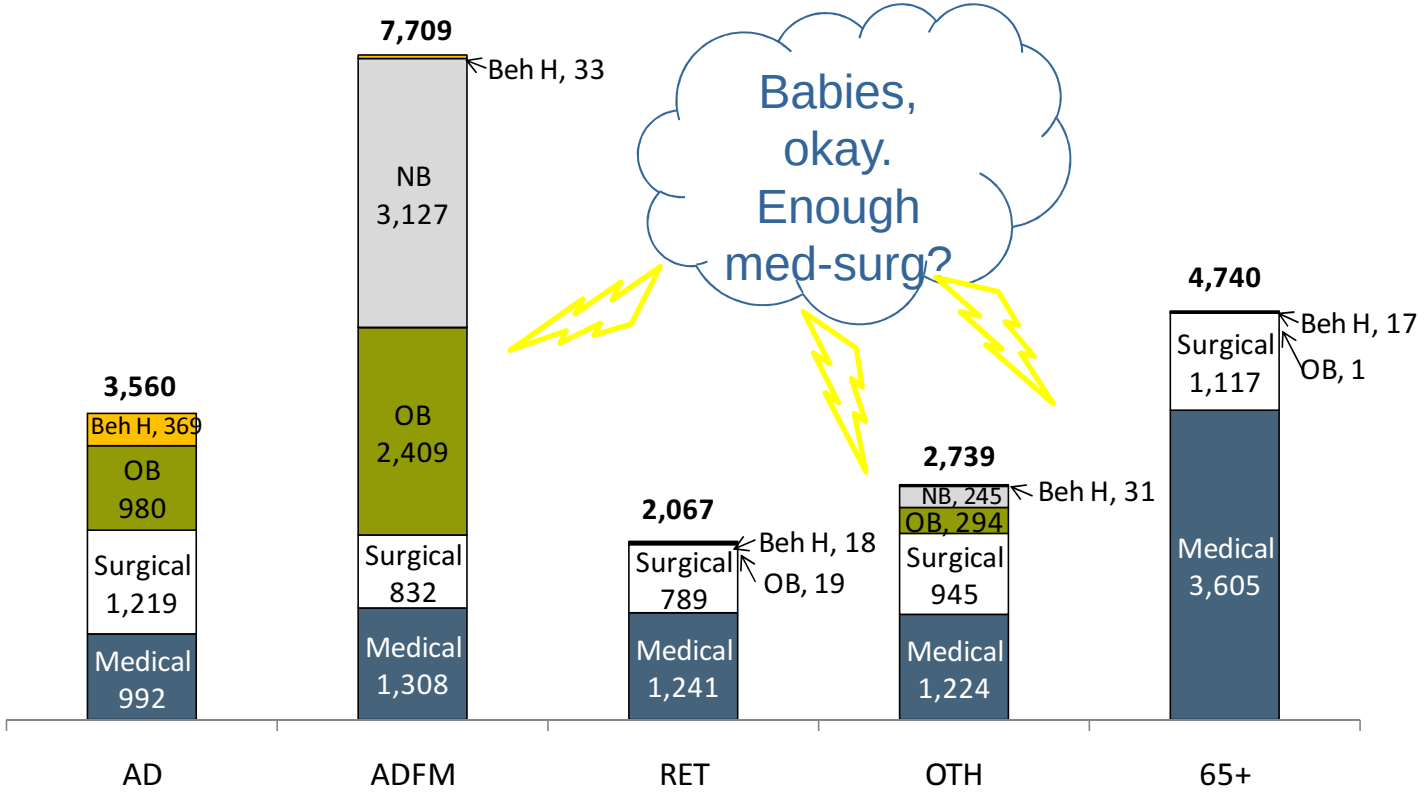


DC – NCR MTF
PC – NCR Facility

* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

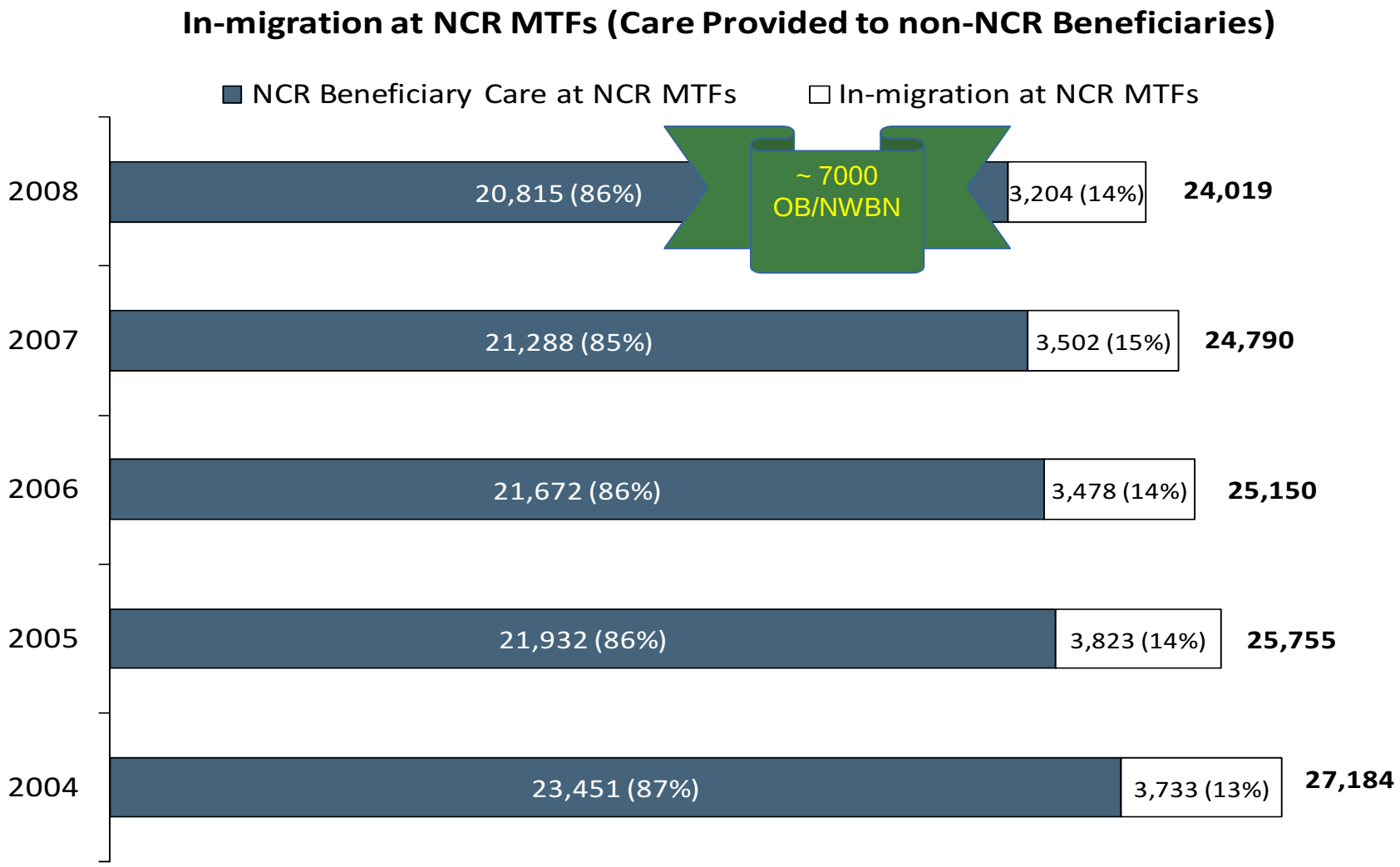
DC Medical & Surgical Cases in NCR*

Number of Inpatient Direct Care Dispositions by Beneficiary Category and Service Line for NCR Beneficiaries at NCR MTFs (2008)



* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

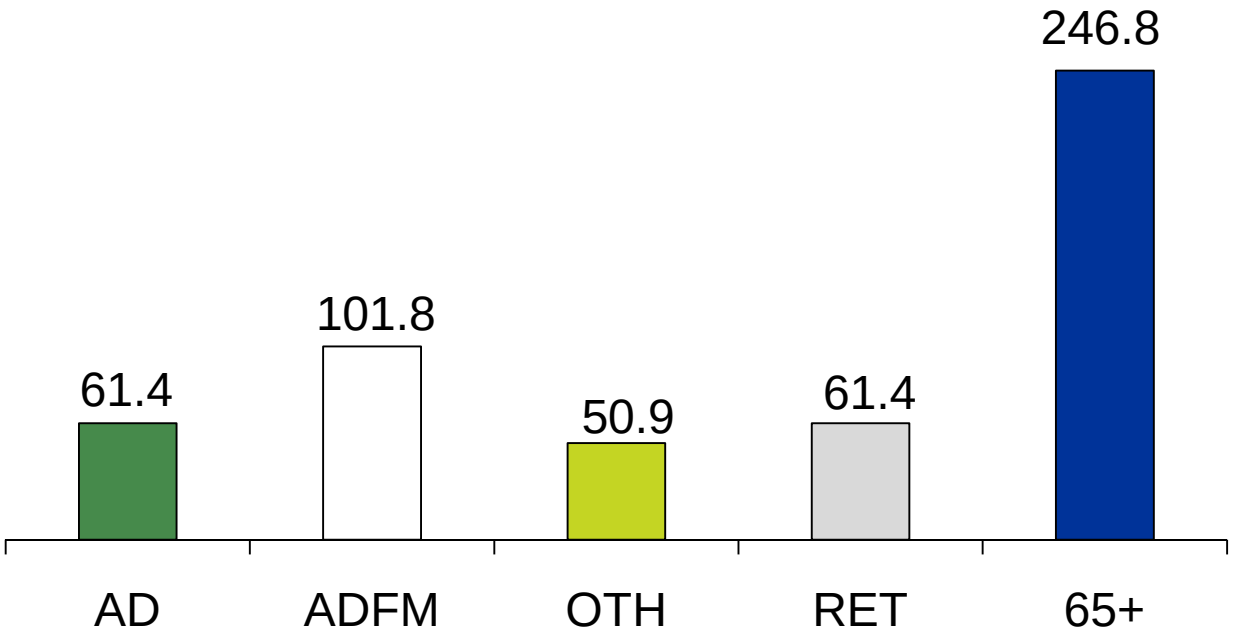
The NCR MTFs have Less Than 15 percent In-migration*



* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

Inpatient Utilization per 1000 in 2015*

Inpatient Use Rate by Beneficiary Category
(2008 A and 2015 Projected)

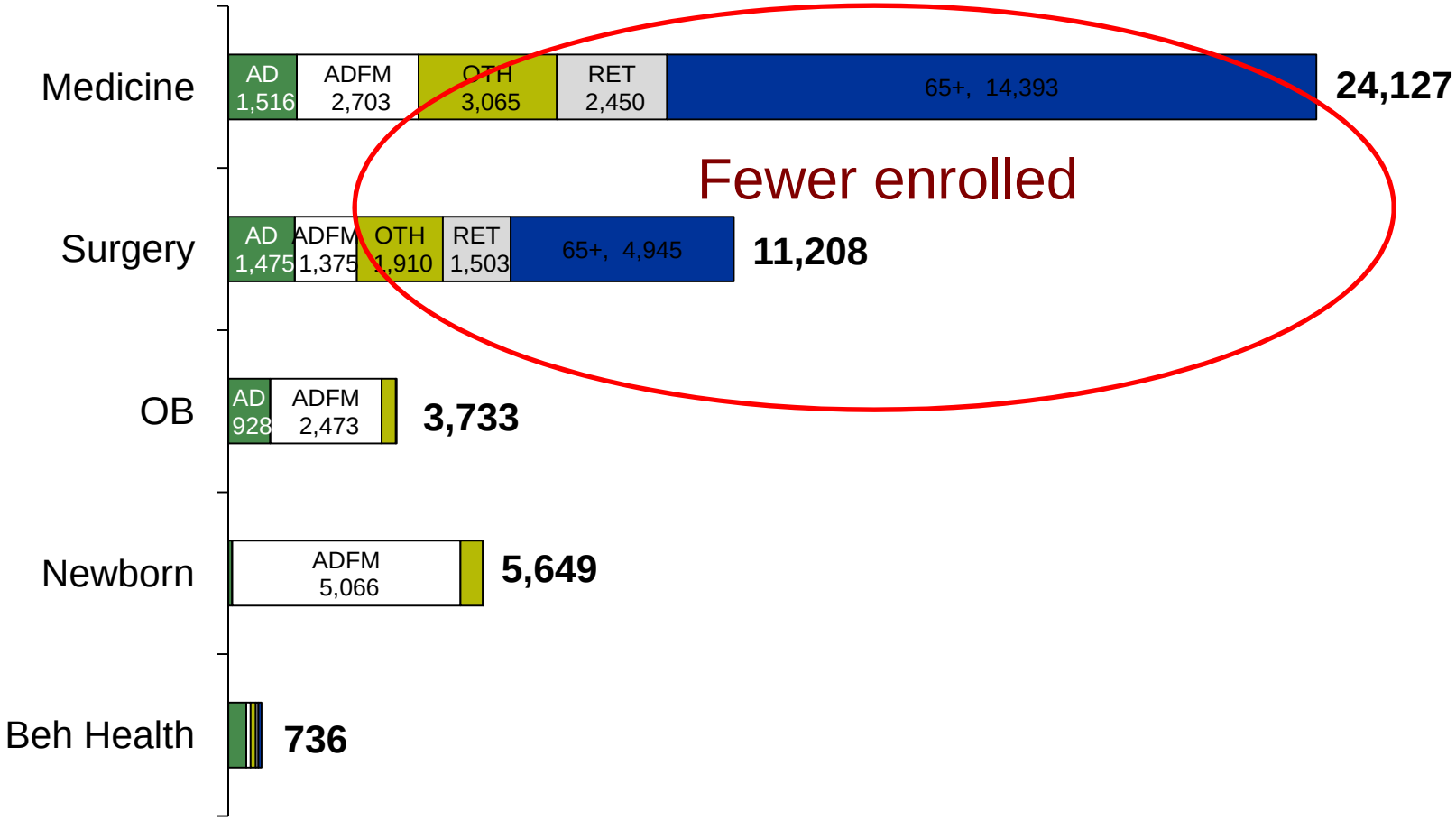


Under 65 years of age

* Noblis, “National Capital Region (NCR) Market Analysis” (Work product delivered November 2009)

Inpatient Demand by Product Line and BenCat*

(2015 Projected)



* Noblis, "National Capital Region (NCR) Market Analysis" (Work product delivered November 2009)

The Operational Art

MISSION ANALYSIS

Essential Mission Tasks

- Primary Care for wounded warriors, AD service members, some ADFM, some others
  - Primary Care Medical Home
  - Family Care Clinics
  - Troop Medical Clinics
  - Wounded Warrior Clinics
  - Medical Readiness Clinics
  - Occupational Health

Essential Mission Tasks

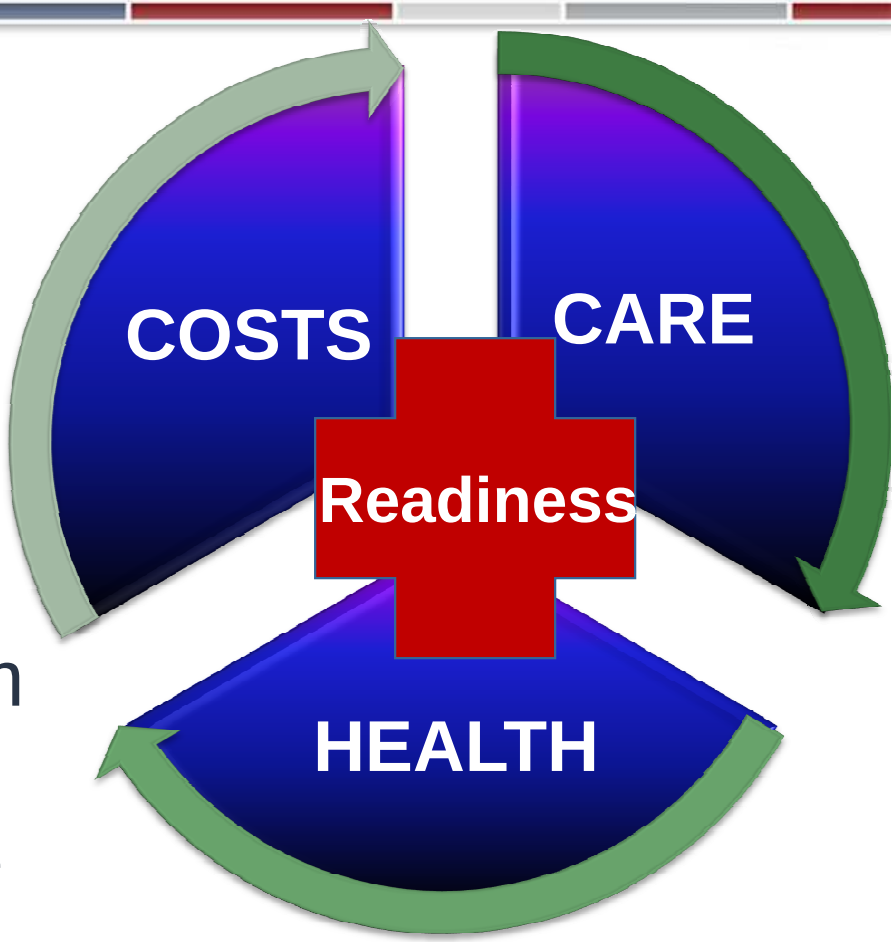
- Casualties
- Wounded Warrior Care
- Medical Readiness
- Public Health
- Medical Administration
- Consequence Management
- Support to civilian authority as directed by Secretary of Defense
- Others within the Quadruple Aim

The Operational Art

THE QUADRUPLE AIM

MHS Quadruple Aim

- Readiness
- Care
- Health
- Cost

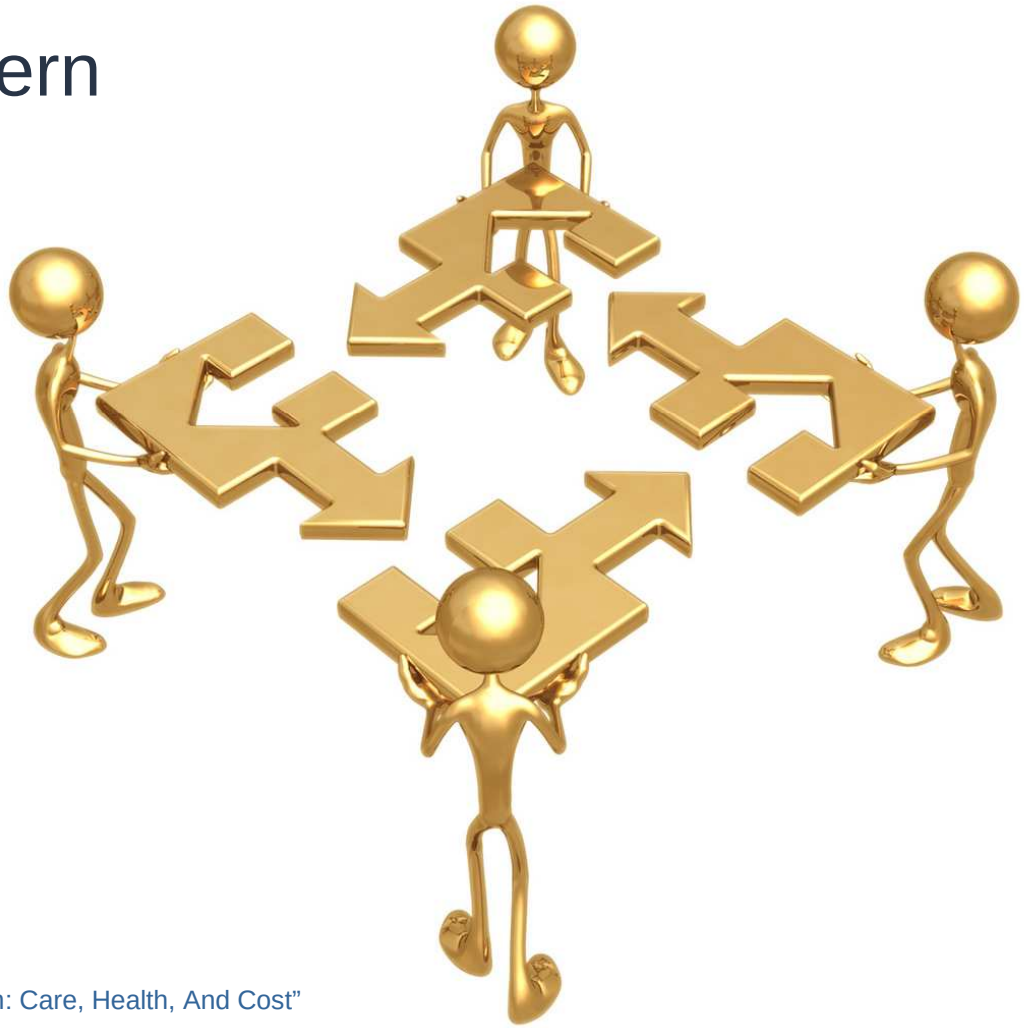


The U.S. healthcare system
"…lacks the capacity to integrate its work over time and across sites of care."*

*Donald M Berwick, TW Nolan, J Whittington "The Triple Aim: Care, Health, And Cost" (*Health Affairs* Vol. 27 No. 3, May/June 2008), p. 759-769.c

Pre-Conditions for Success*

- Population of Concern
- Constraints
- Integrator



*Donald M Berwick, TW Nolan, J Whittington “The Triple Aim: Care, Health, And Cost” (*Health Affairs* Vol. 27 No. 3, May/June 2008), p. 759-769.c

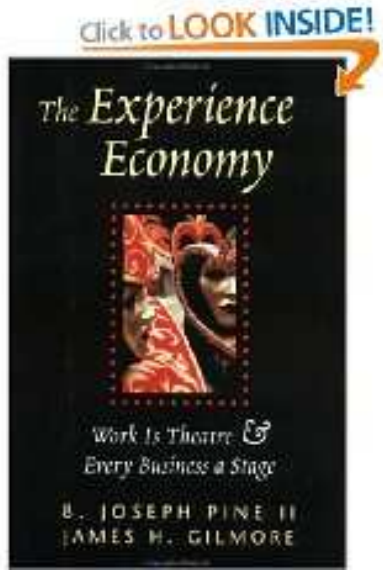
The Quadruple Aim

- The Quadruple Aim as a
  - Strategic End State
  - Operational Effectº
- Unity of Purpose
  - Align responsibility & accountability*
  - Centralized planning and decentralized execution §

º Director for Operational Plans and Joint Force Development (J-7), "Joint Operation Planning, Joint Publication 5-0 (JP5-0)", (26 December 2006, Commander, United States Joint Forces Command, Joint Warfighting Center Code JW100, Suffolk, VA, p. I-13.)
* CJFC, JP1, (2007, chg 1 2009, p. IV-1)
§ Ibid, p. IV-15

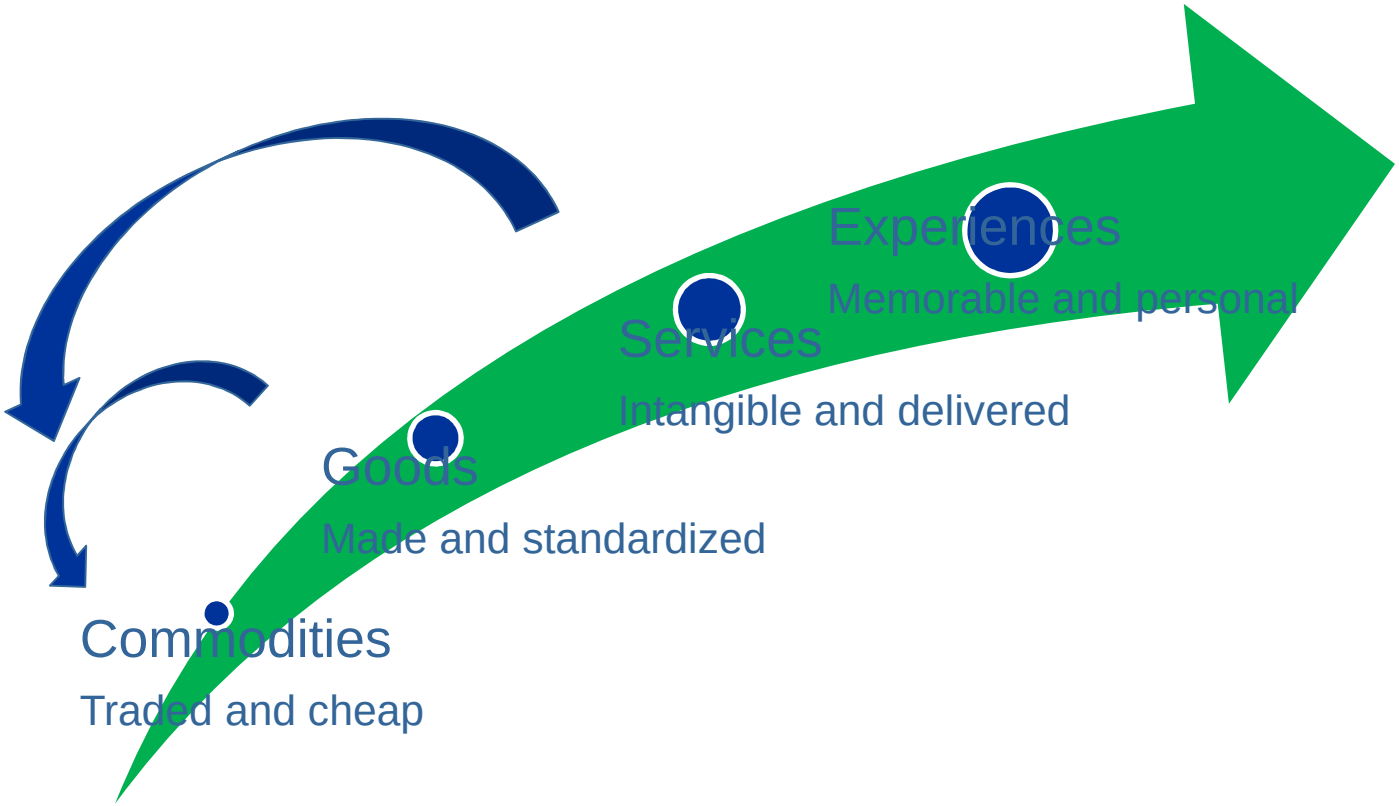
Quadruple Aim meet Economics

- Quadruple Aim includes the IHI Triple Aim
  - Improve the Health of the Population
  - Improve the Patient Experience
  - Control the costs
- What is *Experience*? Ask B. Joseph Pine II*



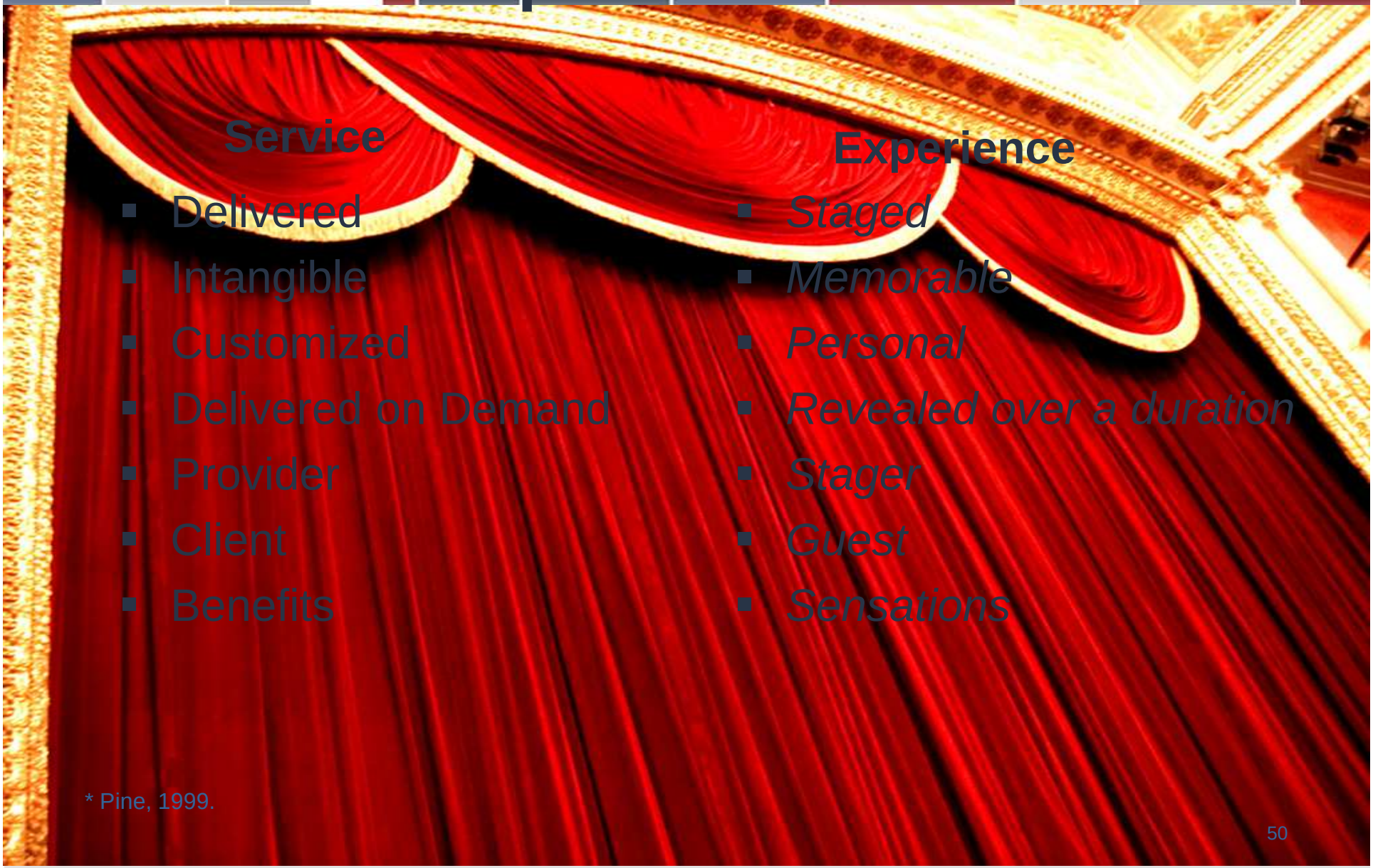
* B. Joseph Pine II, JH Gilmore, "The Experience Economy: Work is Theatre & Every Business a Stage", (1999, Boston, Harvard Business School Press)

The Experience Economy*



* Pine, 1999.

Service or Experience?*



Service

- Delivered
- Intangible
- Customized
- Delivered on Demand
- Provider
- Client
- Benefits

Experience

- *Staged*
- *Memorable*
- *Personal*
- *Revealed over a duration*
- *Stager*
- *Guest*
- *Sensations*

* Pine, 1999.

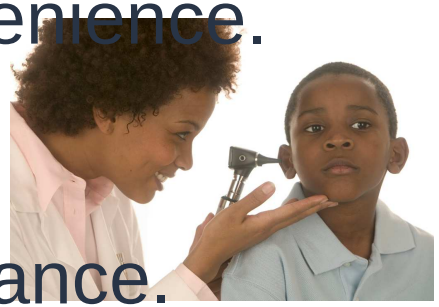
The Experience*

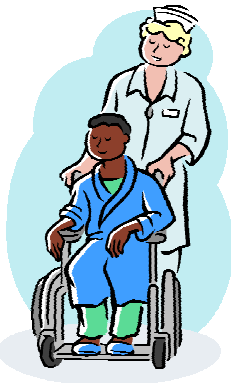
- The customers is the product
- The patients want to be well. And more …
- The experience is a transformation.
- The organization must listen and learn from its customers & respond rapidly
- Render the authentic experience

* Pine, 1999.

Experience

- Patient – Cure. Control. Comfort. Convenience. Competency. Recovery. Knowledge. Information. Mastery. Administration.
- Family – Cure. Control. Comfort. Assurance. Convenience. Competency. Recovery. Knowledge. Information. Mastery. Administration.
- Commands – Cure. Recovery. Assurance. Convenience. Competency. Knowledge. Information. Administration.



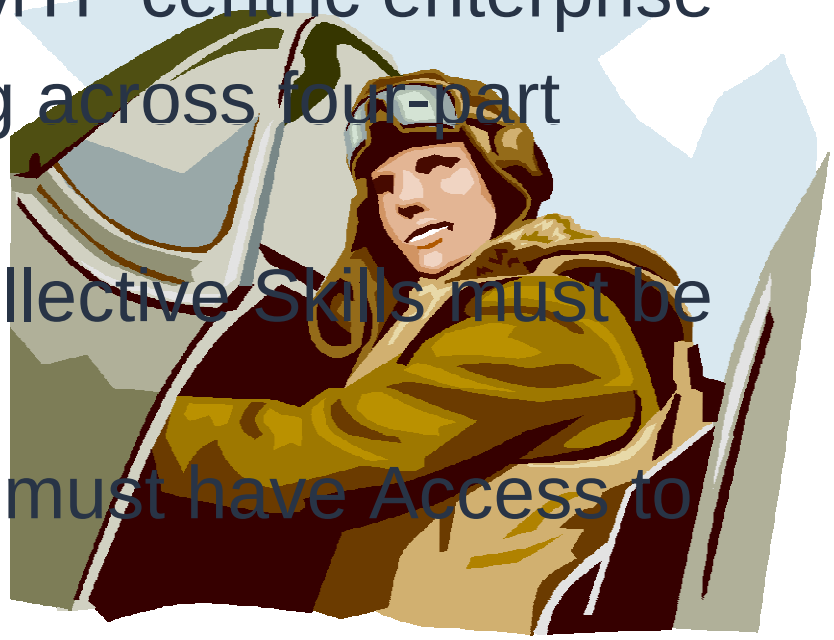


The Operational Art

COURSES OF ACTION

End State: Ready, Deploy, Employ*

- Military Medical Capabilities: Obligations to Service and Joint Warfighters.
  - Operating as a non-MTF centric enterprise
  - The MTFs integrating across four-part platforms
  - Individual Skills & Collective Skills must be sharp
  - Individuals and units must have Access to Patients → How?



* CAPT Kevin Berry, special studies, JTF CAPMED (2010 MHS Conference)

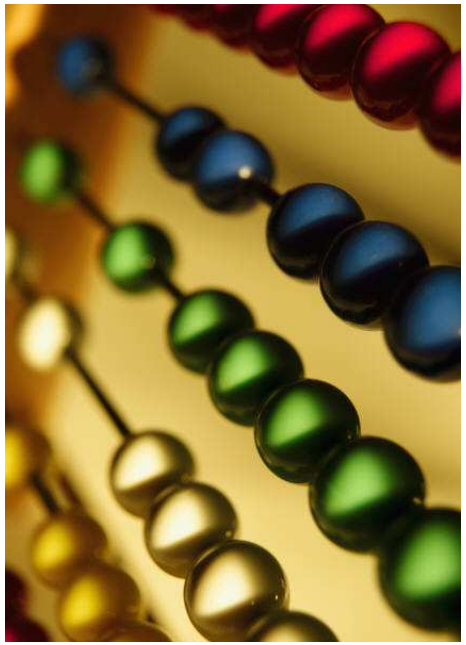
Possible COAs

- **Increase primary care panels** – Can you enroll your way into the case mix you need?
- **Empanel** – Need to change the case mix?
- **ROFRs** – The "Experience Framework"©*
- **Direct Access** – To critical specialties?
  - Risks tying up specialists in primary care.
  - Mission Analysis and COAs?
- **VHA sharing** – Takes time, must play by the rules
  - Start-up capital available through Joint Incentive Fund

* Mei Lin Fung, MS MIT, USA, Baumin Lee, Ph.D, China, "Emerging Trends in Business & Implications for Performance Management in China", September 11, 2007. Copyright 2007 The CIE Institute and 95teleweb (Used with permission of the author.)

Risks

- Primary Care for AD, ADFM only
  - Can't get the volumes and case mix
- Direct Assess for Standard Patients
  - Over commitment
- Need to know your mission
  - End States & Plans
  - Common Operating Picture
  - Stage & Deliver the Experience
  - Rapid Learning / Adaptive Planning



The Operational Art

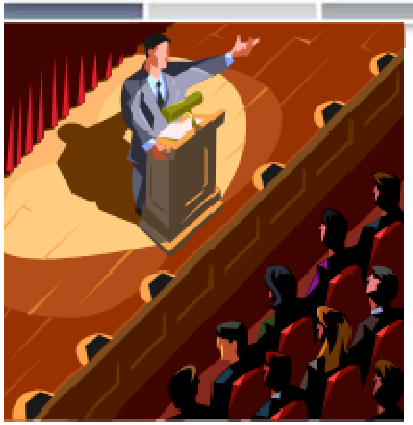
IMPLIED TASKS

Leading Change*

- **Change** is very hard.
  - Bureaucracies: Very stable organizations until the unexpected happens. Culture trumps disruptive innovation or good ideas.
  - Learning Organizations: Good for organizations committed to make incremental change. Low success rates.
  - Transformational Organizations: Usual establish new organization to address a life or death threat.

* Charles Vela, private communication, (Expertech Solutions, 2009)

Eight Core Change Principles*

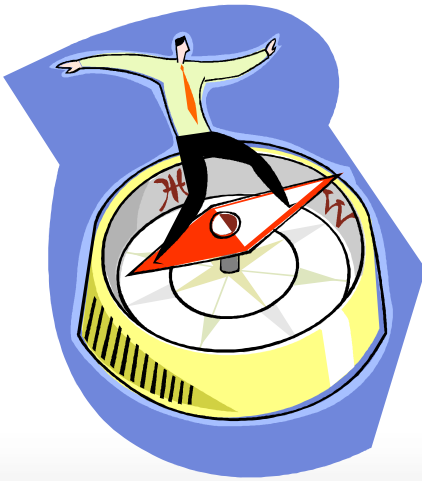


1. Urgency. There must be a clear imperative for change.
2. Guiding coalition. The head of the organization leading change is not enough, there must be a number of people who pull together as a tight highly functional team. There will be power struggles.
3. Powerful vision. Sensible and simple. Anyone can get it.
4. Tell the story. It is a narrative said a thousand times to a thousand people in a thousand ways.

* John P Kotter, Leading Change, (Boston: Harvard Business School Press, 1996)

Eight Core Change Principles*

5. Remove the barriers. Bureaucracies have cultures. Culture is a powerful mental barrier. Real barriers must be found, and they hide.
6. Short term wins. "Quick splashy victories."
7. Keep the energy high. Change does not take root easily, it is fragile.
8. Practice makes a new culture. Anchor the change into organization in everyway.

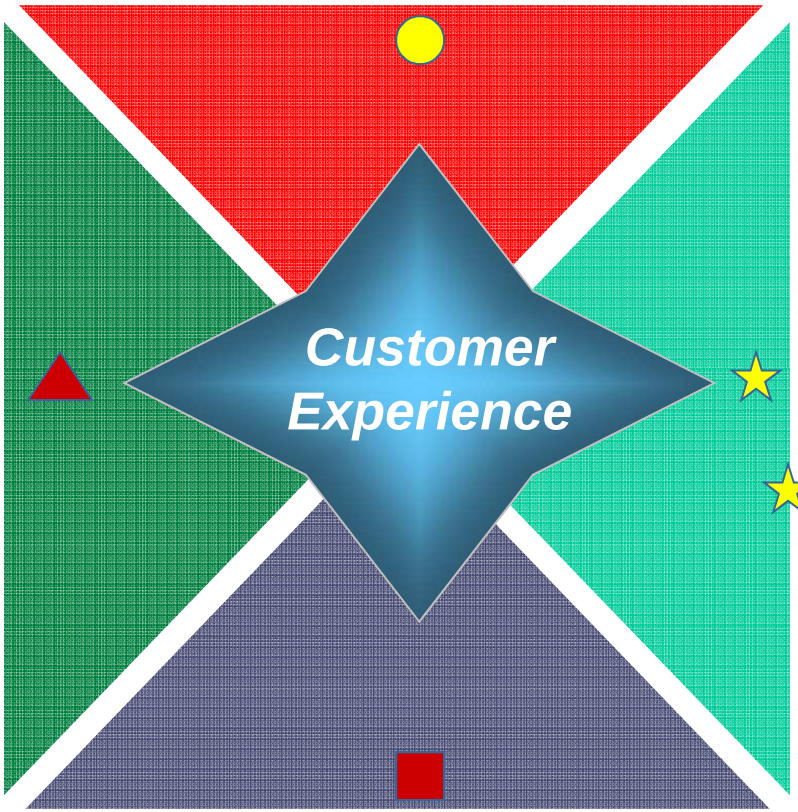


* Kotter, 1996

Customer Experience Framework Today's View*

Channels and touchpoints *are where interactions take place and how they are executed and enabled.*

Tactile performance *is the physical aspect of the interaction, such as consistency, speed, or completeness.*



Emotive performance *is manner in which customers are treated, such as being trustworthy, genuine, or empathetic.*

Products and services *are the tangible goods or saleable services provided to the customer.*

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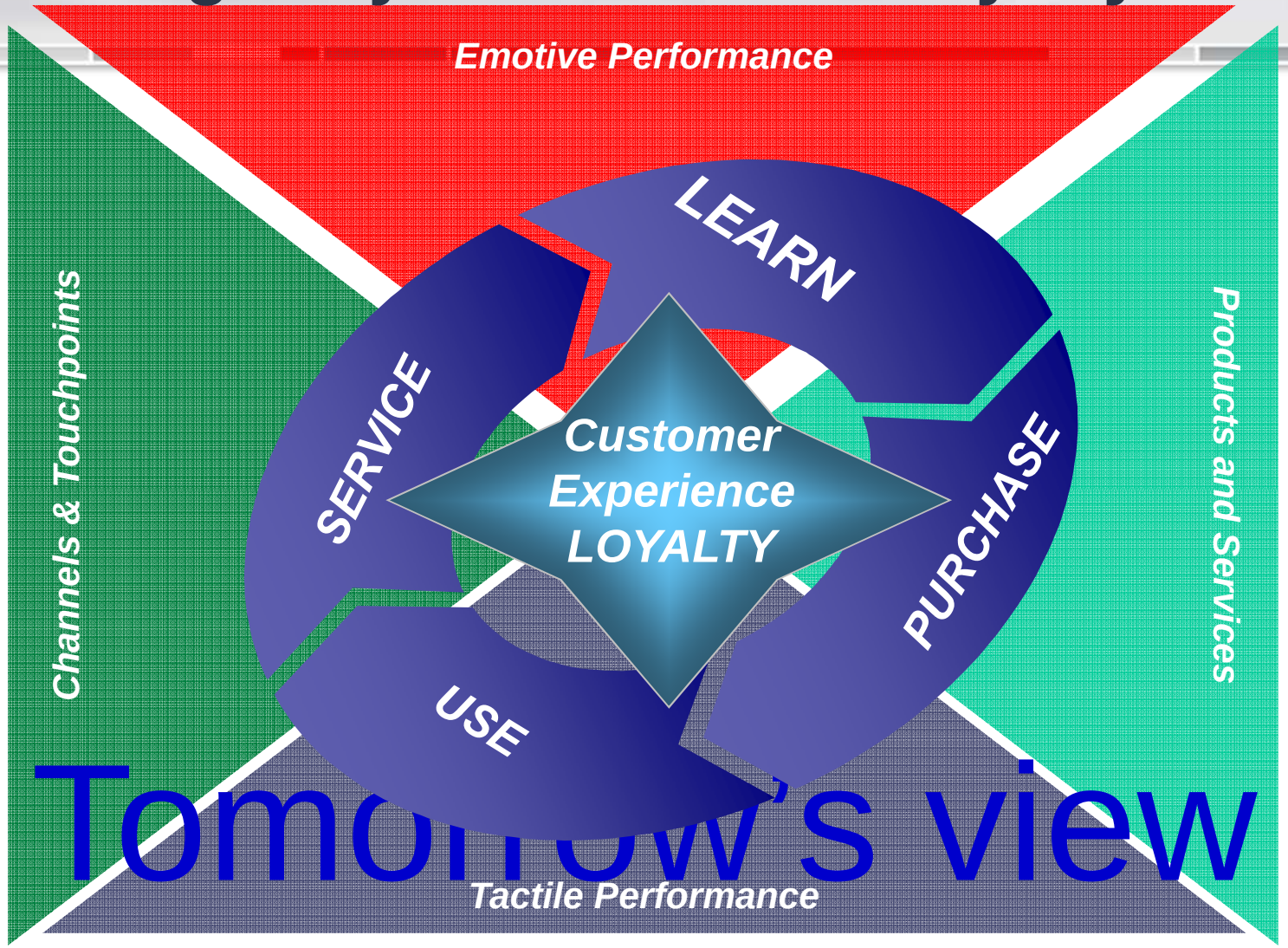
Learning: Key to Customer Loyalty*



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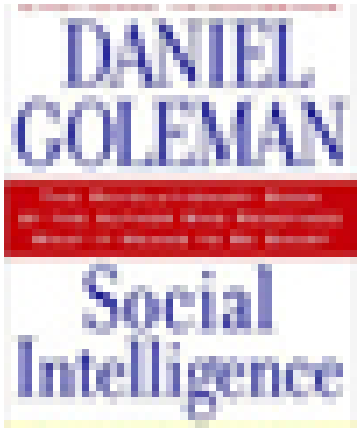
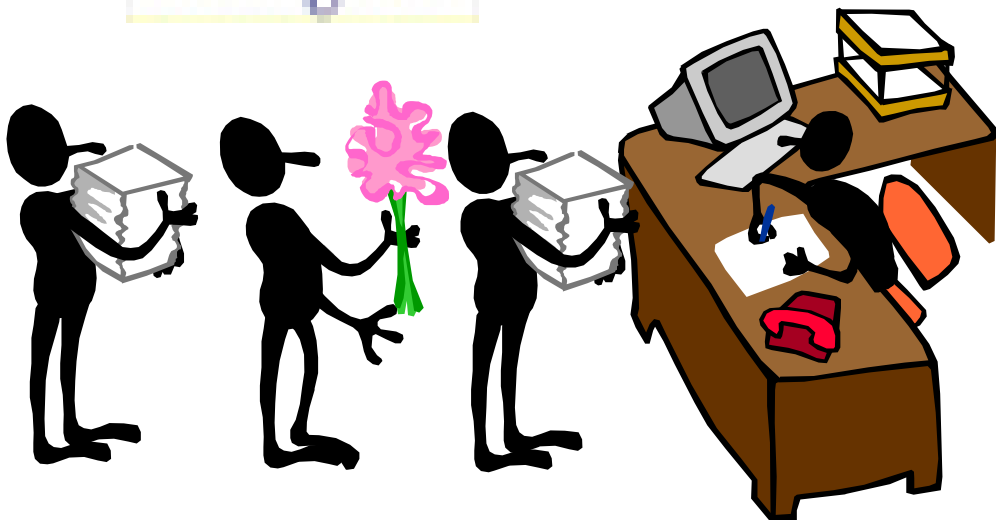
Skills Required to Gain Service Competitive Advantage*

- Emotional Intelligence
  - Communication skills
  - Results-orientation
  - Problem-solving
  - Handling difficult customers



- Social Intelligence
  - Leadership
  - People management
  - Impact and Influence
  - Team skills
  - Customer service skills



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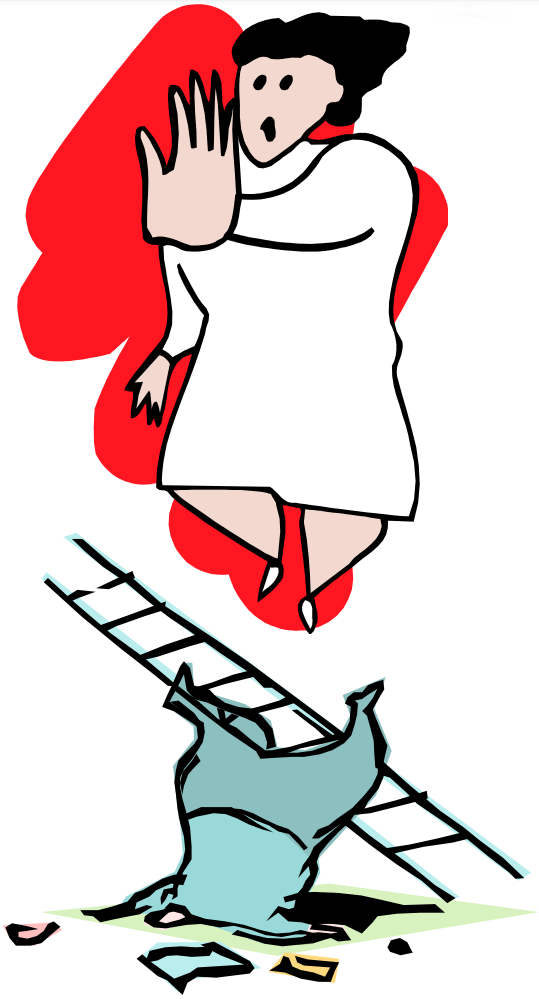
What destroys Customer Trust?

- Failing to keep promises
- Failing to deliver or arrive at scheduled time
- Hearing from you only when you want something from me
- Asking me the same things over and over again
- Providing new customers with better offers than existing customers
- Hidden costs to customers
- Frontline employees refusing to take responsibility
- Anonymous decision makers
- Hiding in the bureaucracy or behind technology



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What builds Trust in Customers?

- Keeping your promises
- Acknowledging my (customer) loyalty
- Providing the information for customer to make a good decision
- Admitting mistakes, saying sorry and fixing things
- Providing relevant, valuable advice and information
- Giving me the actual names of 'real' people I can talk to and contact, real signatures
- Getting my name right when you call or write
- Calling to ask 'how are things?
- Talking to people who can make decisions
- Talking to people who tell the truth

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Summary

- “Enrollment” is a term used to describe an insurance product.
- Delivering “Primary Care” might be an essential mission task but building primary care capability might not be an effective way to achieve other essential mission tasks.
- Strategic & Operational expectations are high
  - Quadruple Aim – readiness, care, health, cost
- Assess the mission & risks. Plan. Act. Learn. Adapt.